

5-42
17-39
X32873

FILED JUN 11 1943
Registration District No. 293

Primary Registration District No. 6005

Registrar's No.

1. PLACE OF DEATH:

(a) County Rale

(b) City or town Rural, Spencer Twp
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
at home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) Life time

In this community _____ (Specify whether years, months or days) Life time

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Rale 87

(c) City or town Rural (If outside city or town limits, write "RURAL") 0

(d) Street No. Near Frankford Mo. (if rural, give location) 0

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME DONTAY Charline Pearl

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Cobd 6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: Feb. 28 1943
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>1</u>	<u>1</u>	<u>25</u>	hr. _____ min. _____

9. Birthplace Rale Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Joe Pearl

13. Birthplace Pike Mo. 0
(City, town, or county) (State or foreign country)

14. Maiden name Mary Mitchell

15. Birthplace Pike Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Joe Pearl

(b) Address Frankford Mo.

17. (a) Removal (b) Date thereof April 23 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Louisiana, Mo.

18. (a) Signature of funeral director Harner & Stone

(b) Address Louisiana Mo.

19. (a) 4-24-43 (b) R.S. Berkley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 23
year 1943 hour 5:30 minute A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h. _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature Dr. J. ... (other) _____

Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 6-43-1036

Date Filed JUN 9 1949

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ~~or by~~

....., Registered Apprentice No.

working under my personal supervision.

Signed

J. B. Sterne

Licensed Embalmer No. 4039

P. O. Address Louisiana Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 293

Primary Registration District No. 6000

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Ralls
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Dorothy Charline Pearl

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb 2 1904
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) Mo.

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL.")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April 3
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; to _____, 19____;

that I last saw him alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration _____

Broncho

Due to No Complaint

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations 107

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place) (2) Means of injury _____

23. Signature D. M. Jones (M. D. or other) _____

Address Frankford Mo Date signed 6/2/43

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTAL

INTERVIEW 3

PHYSICIAN

Underline the cause to which death should be charged statistically.

2 10 10
1-10-10